

# Oregon Declaration Form for Reduced Non-Tobacco Rates

To be completed by the member, 21 years or older, who stopped using tobacco products.

## MEMBER INFORMATION

Member name \_\_\_\_\_

Street address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP code \_\_\_\_\_

Date of birth \_\_\_\_\_ Medical record number \_\_\_\_\_

Subscriber name on account \_\_\_\_\_

## DECLARATION

1. I have not used tobacco products four times or more per week in the past six months (except for religious or ceremonial purposes).

*Tobacco products include cigarettes, pipes, and cigars, as well as snuff and chewing or other smokeless tobacco.*

2. The most recent date on which I used any tobacco product: \_\_\_\_\_

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### Please read the following before signing this form.

By signing below, I certify that all of the information in this declaration form is true. I understand that it may be a crime to knowingly provide any false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of insurance benefits.

## SIGNATURE

Member signature \_\_\_\_\_ Date (MM/DD/YYYY) \_\_\_\_\_

Subscriber signature \_\_\_\_\_ Date (MM/DD/YYYY) \_\_\_\_\_

### Mail this completed form to:

Kaiser Foundation Health Plan of the Northwest  
Attn: Individuals and Families Plans  
P.O. Box 23127  
San Diego, CA 92193-9921

Or fax to 1-855-355-5334

**Nonsmoker rates are effective the first billing period following receipt and approval of this declaration form by Kaiser Foundation Health Plan of the Northwest. For further information, call 1-800-494-5314.**